

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

647

CERTIFICATE OF DEATH

00639

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 10 Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett Co. Memorial Hospital				d. STREET ADDRESS Route # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Ahern				4. DATE OF DEATH Month January Day 13 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 13, 59	
9. AGE (In years last birthday) 10		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min. 10		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? -----	
13. FATHER'S NAME Roy Jean Ahern				14. MOTHER'S MAIDEN NAME Hazel Marie Pifer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT "Mother" Hazel Marie Ahern, Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia (5 mos gestation) 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ----- DUE TO (c) -----				INTERVAL BETWEEN ONSET AND DEATH 10 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-13 , 19 59 , to 1-13 , 19 59 , that I last saw the deceased alive on 19 , and that death occurred at 6:40 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5821st Ave. - 1 (1-13-59) DATE SIGNED -----							
ACTUAL SIGNATURE James H. Feaster Jr. M.D.				PHYSICIAN'S NAME (Type) Oakland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		1/14/1959		John Our Cemetery		near Mt. Lake Park, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Hinton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE JAN 19 59	
				24b. REGISTRAR'S SIGNATURE Charles S. Pifer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2070161XVO

CERTIFICATE OF DEATH

RODNEY

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of health officer		18. Signature of board of health		19. Signature of city council		20. Signature of state board of health	
21. Signature of state board of health		22. Signature of state board of health		23. Signature of state board of health		24. Signature of state board of health	
25. Signature of state board of health		26. Signature of state board of health		27. Signature of state board of health		28. Signature of state board of health	
29. Signature of state board of health		30. Signature of state board of health		31. Signature of state board of health		32. Signature of state board of health	
33. Signature of state board of health		34. Signature of state board of health		35. Signature of state board of health		36. Signature of state board of health	
37. Signature of state board of health		38. Signature of state board of health		39. Signature of state board of health		40. Signature of state board of health	
41. Signature of state board of health		42. Signature of state board of health		43. Signature of state board of health		44. Signature of state board of health	
45. Signature of state board of health		46. Signature of state board of health		47. Signature of state board of health		48. Signature of state board of health	
49. Signature of state board of health		50. Signature of state board of health		51. Signature of state board of health		52. Signature of state board of health	
53. Signature of state board of health		54. Signature of state board of health		55. Signature of state board of health		56. Signature of state board of health	
57. Signature of state board of health		58. Signature of state board of health		59. Signature of state board of health		60. Signature of state board of health	
61. Signature of state board of health		62. Signature of state board of health		63. Signature of state board of health		64. Signature of state board of health	
65. Signature of state board of health		66. Signature of state board of health		67. Signature of state board of health		68. Signature of state board of health	
69. Signature of state board of health		70. Signature of state board of health		71. Signature of state board of health		72. Signature of state board of health	
73. Signature of state board of health		74. Signature of state board of health		75. Signature of state board of health		76. Signature of state board of health	
77. Signature of state board of health		78. Signature of state board of health		79. Signature of state board of health		80. Signature of state board of health	
81. Signature of state board of health		82. Signature of state board of health		83. Signature of state board of health		84. Signature of state board of health	
85. Signature of state board of health		86. Signature of state board of health		87. Signature of state board of health		88. Signature of state board of health	
89. Signature of state board of health		90. Signature of state board of health		91. Signature of state board of health		92. Signature of state board of health	
93. Signature of state board of health		94. Signature of state board of health		95. Signature of state board of health		96. Signature of state board of health	
97. Signature of state board of health		98. Signature of state board of health		99. Signature of state board of health		100. Signature of state board of health	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 8 FilmG237 1-20-59 et

648

CERTIFICATE OF DEATH

00640

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett.</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Garrett.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Friendsville, Md.</u>		LENGTH OF STAY (in this place) <u>70 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>-----</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>-----</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Harry J. Black.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 6th 19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1871 Jan 28, 1872</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O Agent.</u>		11. BIRTHPLACE (State or foreign country) <u>Somerfield, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert G. Black.</u>				14. MOTHER'S MAIDEN NAME <u>Susan Brownfield.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u>		16. SOCIAL SECURITY NO. <u>705-03 9930</u>		17. INFORMANT & ADDRESS <u>Mrs. Lillian Beachley Friendsville, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>450.0 IMMEDIATE CAUSE</u> (A) <u>Cardio-respiratory Failure</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Generalized Arteriosclerosis</u>							
(C) <u>Aging</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Parkinson's Disease</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-20-58</u> to <u>1-6-</u> 19 <u>59</u> , that I last saw the deceased alive on <u>1-6</u> 19 <u>59</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Pedro Rivera</u>				ADDRESS (Street, city, town, state) <u>1/8/59</u>			
DATE <u>JAN 14 '59</u>				M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-9-59</u>		NAME OF CEMETERY OR CREMATORY <u>ADDISON CEMETERY.</u>		LOCATION (City, town, or county) (State) <u>ADDISON. PA.</u>	
24. REC'D BY REGISTRAR DATE <u>JAN 14 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur L. H.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. B. Richebarger, Addison, Pa.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

648

CERTIFICATE OF DEATH

Reg. Dist. No.

00641

1. PLACE OF DEATH a. COUNTY Barrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Preston	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 1 month	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Terra Alta 85X-3		d. STREET ADDRESS 216 Aurora Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virginia Middle Frances Last Bohon		4. DATE OF DEATH Month January Day 27th Year 1959	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 2, 1870
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 2 Days 25	
IF UNDER 24 HRS. Hours 25 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. George, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Taylor White		14. MOTHER'S MAIDEN NAME Elizabeth Jane Mason	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Pauline Fitzer, Terra Alta, W.Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) 15 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 12, 1955 , to Jan 4, 1959 , that I last saw the deceased alive on Jan 2, 1959 , and that death occurred at 8:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Terra Alta, W.Va. DATE SIGNED Jan. 28, 1959 ACTUAL SIGNATURE William Harriman M.D. PHYSICIAN'S NAME (Type) WILLIAM HARRIMAN M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/29/59	
22c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery		22d. LOCATION (City, town, or county) (State) Terra Alta, West Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE P. R. Watson, Terra Alta, W.Va.		ADDRESS Md. F.D. License No. A 6834	
24a. REC'D BY REGISTRAR JAN 29 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

650

CERTIFICATE OF DEATH

00642

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jennings</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Jennings</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Nelson Broadwater</u>		4. DATE OF DEATH Month Day Year <u>January 18 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1899 March 27, 1907</u>
9. AGE (In years lost birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Avilton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lloyd E. Broadwater</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Ross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-10-5383</u>	
17. INFORMANT Address <u>Mrs. Vespa Broadwater, Jennings, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute myocardial infarction</u> DUE TO (b) <u>Coronary insufficiency</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 18, 1959</u> , to <u>Jan. 18, 1959</u> , that I last saw the deceased alive on <u>Jan. 18, 1959</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Paige Strong</u> M.D.		ADDRESS (Street, city or town, state) <u>Grantsville, Md.</u> DATE SIGNED <u>1/21/59</u>	
PHYSICIAN'S NAME (Type) <u>A. Paige Strong, M.D.</u>		<u>Grantsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville</u>		22d. LOCATION (City, town, or county) (State) <u>Grantsville, Garrett, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u>		ADDRESS <u>Grantsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS

BROWN

EDWARD BROWN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF MARRIAGE

NAME OF SPOUSE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00643

Reg. Dist. No.

651

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> c. LENGTH OF STAY IN 1b <u>6 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Oakland</u> d. STREET ADDRESS <u>115 Oak Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Mona Grace Brown</u>				4. DATE OF DEATH Month <u>January</u> Day <u>29</u> Year <u>1959</u>									
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept., 9, 1904</u>		9. AGE (In years last birthday) <u>54 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Beckman</u>						14. MOTHER'S MAIDEN NAME <u>Lilly Walters</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Charles L. Brown, 115 Oak St. Oakland, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>Crushed chest</u> IMMEDIATE CAUSE (a) <u>816X</u> DUE TO <u>Cereberal concussion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u>Compound fracture right leg.</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>11 hours</u> <u>11 hours</u> <u>11 hours</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Head on auto collision near Oakland, Md. 6:15 P.M. 1-28-59</u>									
20c. TIME OF INJURY Month <u>1-28-59</u> Day <u>19</u> Year <u>19</u> <u>6:15</u> Hour <u> </u> <u>p. m.</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road Rt. 29</u>				20f. (City or town) <u>Nr. Oakland Garrett, Md.</u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>(ACTING)</u>						DATE SIGNED <u>1-29-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/31/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Thayerville Cemetery</u>				22d. LOCATION (City, town, or county) <u>Garrett Co., Maryland.</u> (State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Al. Leighton</u>						ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00644

652

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 24 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GRACE Middle BRYDON Last BRYDON				4. DATE OF DEATH Month JANUARY Day 15 Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/9/74		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Grafton, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Blue				14. MOTHER'S MAIDEN NAME Don't Know			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT SUSAN PATTISON		Address PIEDMONT, W.VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Atherosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:33 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Richard F. Leighton M.D.				Jan. 17-1959			
PHYSICIAN'S NAME (Type) RICHARD F. LEIGHTON, M.D.				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 19/59		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. A. Redlock Jr.				24a. REC'D BY REGISTRAR ADDRESS Piedmont, W.Va.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

653
CERTIFICATE OF DEATH

00645

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gormaniam, W.Va.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Gormaniam, W.Va.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		/d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Franklin James Childs		4. DATE OF DEATH Month Day Year Jan. 15, 1959 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 5, 1871
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY W.Va.	
11. BIRTHPLACE (State or foreign country) W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jessie Childs		14. MOTHER'S MAIDEN NAME Sarrah Feathers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT James L. Childs Gormaniam, W.Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio - Vascular - Renal Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Large Scrotal hernia (bilateral)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 13, 1959 to Jan. 15, 1959 , that I last saw the deceased alive on Jan. 13, 1959 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph Colandrella		ADDRESS (Street, city or town, state) Ligonier, Md.	
PHYSICIAN'S NAME (Type) Ralph CAHANDRELLA		DATE SIGNED Jan 17 - 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 17, 1959	
22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town, or county) (State) Gormaniam, W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spizzle		ADDRESS Davis, W.Va.	
24a. REC'D BY REGISTRAR DATE JAN 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00646

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md-Penn b. COUNTY Bedford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloomington		c. LENGTH OF STAY IN 1b 30 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D. 3 Bedford 75 x 3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George First Washington Middle Cover Last				4. DATE OF DEATH Jan Month 26 Day 19 59 Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1905		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William Cover				14. MOTHER'S MAIDEN NAME Bertha Boal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-20-6513		17. INFORMANT Address Stanley Cover-Bedford, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Coronary Sclerosis, Left Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis, Left (c) Coronary Sclerosis, Left DUE TO Coronary Sclerosis, Left couse lost, (c) Coronary Sclerosis, Left						INTERVAL BETWEEN ONSET AND DEATH Sudden -----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Noturol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James H. Feaster, Jr. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES H. FEASTER, JR. MD (ACTING)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Jan. 26, 1959		22c. NAME OF CEMETERY OR CREMATORY Westernport, Md.		22d. LOCATION (City, town, or county) (State) Bedford, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE E. L. Boal				24a. REC'D BY REGISTRAR DATE JAN 28 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

655

CERTIFICATE OF DEATH

00647

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 2½ yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppett Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cora Middle Duffy Last Dailey		4. DATE OF DEATH Month January Day 11 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1879
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Duffy		14. MOTHER'S MAIDEN NAME Emma Tralup	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Cuppett Nursing Home		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 1957 to June 1959 , that I last saw the deceased alive on June 5, 1959 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE E. I. Baumgartner M.D. 25 Cedar St. DATE SIGNED 1/12/59 PHYSICIAN'S NAME (Type) E. I. Baumgartner, M. D. Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/1959	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hager		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JAN 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hager	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF INTERVIEW

INTERVIEWER

DATE OF REGISTRATION

REGISTRAR

DATE OF ENTRY

ENTRY CLERK

DATE OF FILING

FILING CLERK

DATE OF POSTING

POSTING CLERK

DATE OF INDEXING

INDEXING CLERK

DATE OF ARCHIVING

ARCHIVING CLERK

DATE OF DESTRUCTION

DESTRUCTION CLERK

DATE OF RECOVERY

RECOVERY CLERK

DATE OF RE-ENTRY

RE-ENTRY CLERK

DATE OF RE-INDEXING

RE-INDEXING CLERK

DATE OF RE-ARCHIVING

RE-ARCHIVING CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00648

656

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin		c. LENGTH OF STAY IN 1b 46 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin	
3. NAME OF DECEASED (Type or print) First Rebecca Middle Jane Last DeWitt		4. DATE OF DEATH Month January Day 31 , Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1884
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 10 Days 17	IF UNDER 24 HRS. Hours 10 Min. 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) near Sang Run, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Abraham Thomas		14. MOTHER'S MAIDEN NAME Sarah Teets	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Evelyn P. DeWitt, Crellin, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PLACENTA OBSTRUCTION 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MASSIVE PEPTIC ULCER DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 55 , to January , 19 59 , that I lost the deceased alive on January 30 , 19 59 , and that death occurred at 1:50 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2508a st DATE SIGNED 1/31/59 ACTUAL SIGNATURE E. Irving Baumgartner M.D. E. Irving Baumgartner PHYSICIAN'S NAME (Type) E. IRVING BAUMGARTNER OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Feb. 2, 1959	
22c. NAME OF CEMETERY OR CREMATORY Hoyes Cemetery		22d. LOCATION (City, town, or county) (State) Hoyes, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE P. R. Watson ADDRESS Terra Alta, W. Va. Md. F.D. License No. A 6834		24a. REC'D BY REGISTRAR DATE FEB 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

VS A1S (4)
1SM 10/57

MASSACHUSETTS STATE DEPARTMENT OF CORRECTIONS—BOSTON, 18

658

CERTIFICATE OF DEATH

Reg. Dist. No.

00650

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,	c. LENGTH OF STAY IN 1b 2 Months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Friendsville,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home		d. STREET ADDRESS 2 Mi. West Friendsville	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle J. Last Frantz		4. DATE OF DEATH January 22, 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1874
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Wesley J. Frantz		14. MOTHER'S MAIDEN NAME Susan Ross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Merle D. Frantz		Address Friendsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterioscientific Cardio - Renal Disease DUE TO (c) 10 years			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-1- 19 58 to 1-21- 19 59 , that I last saw the deceased alive on 1-21-59 , 19 59 , and that death occurred at 4:30A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James H. Feaster, Jr.		DATE SIGNED 58-2-21- OAKLAND - 1-23-59	
PHYSICIAN'S NAME (Type) James H. Feaster, Jr., M. D.		Oakland, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/24/1959	22c. NAME OF CEMETERY OR CREMATORY Blooming Rose Cemetery near Friendsville, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Al Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR JAN 26 '59
		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED</p>		<p>AGE</p>		<p>SEX</p>		<p>RACE</p>	
<p>DATE OF BIRTH</p>		<p>DATE OF DEATH</p>		<p>PLACE OF BIRTH</p>		<p>PLACE OF DEATH</p>	
<p>RESIDENCE</p>		<p>CAUSE OF DEATH</p>		<p>MANNER OF DEATH</p>		<p>EDUCATION</p>	
<p>OCCUPATION</p>		<p>RELIGION</p>		<p>DATE OF MARRIAGE</p>		<p>DATE OF DIVORCE</p>	
<p>DATE OF ENTRY INTO STATE</p>		<p>DATE OF ENTRY INTO COUNTRY</p>		<p>DATE OF ENTRY INTO CITY</p>		<p>DATE OF ENTRY INTO WARD</p>	
<p>DATE OF ENTRY INTO HOUSE</p>		<p>DATE OF ENTRY INTO ROOM</p>		<p>DATE OF ENTRY INTO BUILDING</p>		<p>DATE OF ENTRY INTO DISTRICT</p>	
<p>DATE OF ENTRY INTO TOWN</p>		<p>DATE OF ENTRY INTO COUNTY</p>		<p>DATE OF ENTRY INTO STATE</p>		<p>DATE OF ENTRY INTO COUNTRY</p>	
<p>DATE OF ENTRY INTO WORLD</p>		<p>DATE OF ENTRY INTO UNIVERSE</p>		<p>DATE OF ENTRY INTO EXISTENCE</p>		<p>DATE OF ENTRY INTO LIFE</p>	

659

CERTIFICATE OF DEATH

Reg. Dist. No.

00651

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gormanian, W. Va.		c. LENGTH OF STAY IN 1b 70 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Table Rock - Fairview Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle William Last Gordon		4. DATE OF DEATH Month January Day 13 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1873
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired track worker		10b. KIND OF BUSINESS OR INDUSTRY R.R. Co.	
11. BIRTHPLACE (State or foreign country) Virginia.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Gordon		14. MOTHER'S MAIDEN NAME Mary Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. --	
17. INFORMANT Mrs. Dora Gordon		Address R. D. Gormanian, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic poisoning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bright's disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Eggleston, W. Va.		(County) (State)	
21. I certify that I attended the deceased from Jan 12 , 19 59 , to Jan 13 , 19 59 , that I last saw the deceased alive on Jan 13 , 19 59 , and that death occurred at 3:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE N. F. Sabbagh M.D.		ADDRESS (Street, city or town, state) Eggleston, W. Va. DATE SIGNED 1/15/59	
PHYSICIAN'S NAME (Type) N. F. Sabbagh, M. D.		Eggleston, W. Va.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/1959	22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery
22d. LOCATION (City, town, or county) Garrett County, Maryland.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR JAN 19 1959
24b. REGISTRAR'S SIGNATURE Ann D. Frank			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH ONE 10

DATE OF DEATH

DECEASED'S NAME

AGE

SEX

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CAUSE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

660

CERTIFICATE OF DEATH

00652

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Zanie Middle MAUDE Last Kelso				4. DATE OF DEATH Month January Day 16 Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 9, 1884	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Lucian Glover		14. MOTHER'S MAIDEN NAME Amy Snopps	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT W.H. Kelso		Address Accident, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Unknown DUE TO (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hart's Dilatation							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October , 19 57 , to January 16 , 19 59 , that I last saw the deceased alive on January 16 , 19 59 , and that death occurred at 8:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert H. Leighton M.D.				ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md.			
DATE SIGNED 17 Jan 59							
PHYSICIAN'S NAME (Type) Dr. Herbert Leighton, M.D. Oakland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/19/1959		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran Cemetery, Accident, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR JAN 20 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

661

CERTIFICATE OF DEATH

Reg. Dist. No.

00653

1. PLACE OF DEATH o. COUNTY Garrett M		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frederick Lawson Lowdermilk		4. DATE OF DEATH Month Day Year January 27, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1894
9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timber Sawyer		10b. KIND OF BUSINESS OR INDUSTRY Saw Mills	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Lowdermilk		14. MOTHER'S MAIDEN NAME Rebecca Stuck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Frederick Lowdermilk		Address Friendsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung. Rt. C 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 26, 1959 to Jan 27, 1959 , that I last saw the deceased alive on 26 Jan, 1959 , and that death occurred at 11:30 P , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. E. Mance		ADDRESS (Street, city or town, state) Oakland Md	
PHYSICIAN'S NAME (Type) A. E. Mance, M. D.		DATE SIGNED 28 Jan 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/1959	
22c. NAME OF CEMETERY OR CREMATORY Addison Cemetery		22d. LOCATION (City, town, or county) (State) Addison, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DATE FEB 2 59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

662 CERTIFICATE OF DEATH

00654

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Garrett</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Friendsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Friendsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>George Mates</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 13 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 28, 1892</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United State</u>	
13. FATHER'S NAME <u>George Mates</u>				14. MOTHER'S MAIDEN NAME <u>Mary Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Virgie Mates Friendsville, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
141.0 IMMEDIATE CAUSE (A) <u>CARDIO RESPIRATORY FAILURE</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>EXTREME Physical Deterioration</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>CARCINOMA of to base of the Tongue</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>NONE</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>Nov 19 58</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 19 58</u> , to <u>Jan 13 19 59</u> , that I last saw the deceased alive on <u>Jan 13 19 59</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Pedro Rivera</u> M.D.				ADDRESS (Street, city, town, state) <u>Friendsville, Md</u>		DATE SIGNED <u>1/16/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 16, 59</u>		NAME OF CEMETERY OR CREMATORY <u>Blooming Rose</u>		LOCATION (City, town, or county) (State) <u>Friendsville Md.</u>	
24. REC'D BY REGISTRAR DATE <u>JAN 19 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Don J. Newman</u>		ADDRESS <u>Friendsville, Md</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00655

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Grantsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Grantsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Leonard Aloysius McKenzie</u>			4. DATE OF DEATH Month Day Year <u>January 18 19 59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>June 6, 1915</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumbering</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Beachy Lbr. Co.</u>		
11. BIRTHPLACE (State or foreign country) <u>Blondike, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Harry McKenzie</u>			14. MOTHER'S MAIDEN NAME <u>Ida Wilhelm</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>214-16-2368</u>		17. INFORMANT Address <u>Mrs. Izetta McKenzie, Grantsville, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage, diffuse, acute</u> DUE TO <u>Ruptured aneurysm, Circle of Willis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		

21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED <u>1-18-59</u>
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D. (Acting)</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville</u>	22d. LOCATION (City, town, or county) (State) <u>Grantsville, Garrett, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norm Newman</u>		ADDRESS <u>Grantsville, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>JAN 22 '59</u>
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		24c. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

CERTIFICATE OF DEATH

00656

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHAUNCEY Middle LAYMAN Last MILLER				4. DATE OF DEATH Month JANUARY Day 7 Year 19 59			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/7/82	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BLACKSMITH				10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME AMASTIAH MILLER			
14. MOTHER'S MAIDEN NAME ELLIE RODEHEAVER				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. 715-01-9064				17. INFORMANT MARGARET SOLLARS Address MT. LAKE PARK, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Chronic Passive Congestion DUE TO Degenerative Cardio-Vascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 month 2 years 5-10 yrs							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Oakland				20g. (County) Oakland		20h. (State) Md.	
21. I certify that I attended the deceased from July 37 , 19 59 , to January 7 , 19 59 , that I last saw the deceased alive on January 7 , 19 59 , and that death occurred at 1:20 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert F. Leighton				DATE SIGNED Jan 7 1959			
PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M. D.				OAK STREET OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/9/1959		22c. NAME OF CEMETERY OR CREMATORY Addison Cemetery		22d. LOCATION (City, town, or county) (State) Addison, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE JAN 9 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

00657

Reg. Dist. No.

665

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 4 days, 4 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Reaford Middle John Last Purbaugh				4. DATE OF DEATH Month January Day 5 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 21, 1928	
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 74 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk				10b. KIND OF BUSINESS OR INDUSTRY Auto supply store			
11. BIRTHPLACE (State or foreign country) Ohio				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Reaford B. Purbaugh				14. MOTHER'S MAIDEN NAME Ann Irene Lohr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 212-24-1680		17. INFORMANT Address Mrs. Reaford J. Purbaugh, Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONITIS, ACUTE 178X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED METASTATIC CARCINOMA DUE TO (c) PRIMARY SITE TESTICLES							INTERVAL BETWEEN ONSET AND DEATH 5 days 5 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ANEMIA, MARKED							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec , 19 48 , to JAN 4 , 19 59 , that I last saw the deceased alive on 1-4 , 19 59 , and that death occurred at 2:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James H. Feaster, Jr.				ADDRESS (Street, city or town, state) DATE SIGNED Oakland, Md. 1-5-59			
PHYSICIAN'S NAME (Type) Dr. James H. Feaster, Jr.				Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		1/7/1959		Oakland Cemetery		Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Reighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE JAN 9 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLATE 13

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

CERTIFICATE OF DEATH

Reg. Dist. No.

00658

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett Co. Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grover Middle Cleveland Last Sisler		4. DATE OF DEATH Month January Day 24 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1885
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timber Ind.		11. BIRTHPLACE (State or foreign country) Hazleton, W. Va.	
12. CITIZEN OF WHAT COUNTRY? America			
13. FATHER'S NAME Samuel J. Sisler		14. MOTHER'S MAIDEN NAME Mahala Rodeheaver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. 214-32-3585	
17. INFORMANT Chauncey Sisler		Address Friendsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 3 Days 10 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 18 , to 24 Jan , 19 59 , that I last saw the deceased alive on 24 Jan , 19 59 , and that death occurred at 6:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew E. Mance M.D.		ADDRESS (Street, city or town, state) Oakland, Md. DATE SIGNED 25 Jan 59	
PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D.,		Oakland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-26-59	
22c. NAME OF CEMETERY OR CREMATORY Blooming Rose Ceme.		22d. LOCATION (City, town, or county) (State) Friendsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Rodaheaver, Markleysburg, Pa.		24a. REC'D BY REGISTRAR JAN 29 1959	
24b. REGISTRAR'S SIGNATURE			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar	

CERTIFICATE OF DEATH

Reg. Dist. No.

00659

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 86 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 yrs. Weeks Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Jefferson Last Sowers		4. DATE OF DEATH Month January Day 23, Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1872
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Laborer for self & Others		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Sowers		14. MOTHER'S MAIDEN NAME Mary Margaret Hilberg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) ----	
17. INFORMANT Allen Paugh		Address Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONITIS ACUTE 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF LUNG, Primary DUE TO (c) C metastases			INTERVAL BETWEEN ONSET AND DEATH 2 wks 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-2 , 19 57 , to 1-21 , 19 59 , that I last saw the deceased alive on 1-21 , 19 59 , and that death occurred at 6:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 58 21st Oakland, Md DATE SIGNED 1-23-59			
ACTUAL SIGNATURE James H. Feaster Jr., M. D.		PHYSICIAN'S NAME (Type) Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/25/1959	22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	22d. LOCATION (City, town, or county) (State) Oakland, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR JAN 26 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

668 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00660

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bitteringer</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bitteringer</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>William</u> Last <u>Stark</u>				4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 24, 1893</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Bitteringer, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter G. Stark</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Slaubaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>220-26-9371</u>		17. INFORMANT Address <u>Mrs. Sara Stark, Bitteringer, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hanging By Neck</u> 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Feaster Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-20-59</u>	
EXAMINER'S NAME (Type) <u>JAMES H. FEASTER JR. (Acting)</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bitteringer</u>		22d. LOCATION (City, town, or county) (State) <u>Bitteringer, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ron J. Newman</u>				ADDRESS <u>Grantsville, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. OCCASION OF DEATH		9. CAUSE OF DEATH	
10. MANNER OF DEATH		11. SIGNATURE OF MEDICAL EXAMINER		12. SIGNATURE OF WITNESS	
13. SIGNATURE OF CORONER		14. SIGNATURE OF JURY		15. SIGNATURE OF JUDGE	
16. SIGNATURE OF CLERK		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF TOWNSHIP CLERK	
19. SIGNATURE OF VILLAGE CLERK		20. SIGNATURE OF CITY CLERK		21. SIGNATURE OF COUNTY CLERK	
22. SIGNATURE OF STATE CLERK		23. SIGNATURE OF DEPARTMENT CLERK		24. SIGNATURE OF RECORDS CLERK	
25. SIGNATURE OF HEALTH DEPARTMENT		26. SIGNATURE OF COUNTY DEPARTMENT		27. SIGNATURE OF TOWNSHIP DEPARTMENT	
28. SIGNATURE OF VILLAGE DEPARTMENT		29. SIGNATURE OF CITY DEPARTMENT		30. SIGNATURE OF COUNTY DEPARTMENT	
31. SIGNATURE OF STATE DEPARTMENT		32. SIGNATURE OF DEPARTMENT		33. SIGNATURE OF RECORDS	
34. SIGNATURE OF HEALTH		35. SIGNATURE OF COUNTY		36. SIGNATURE OF TOWNSHIP	
37. SIGNATURE OF VILLAGE		38. SIGNATURE OF CITY		39. SIGNATURE OF COUNTY	
40. SIGNATURE OF STATE		41. SIGNATURE OF DEPARTMENT		42. SIGNATURE OF RECORDS	
43. SIGNATURE OF HEALTH		44. SIGNATURE OF COUNTY		45. SIGNATURE OF TOWNSHIP	
46. SIGNATURE OF VILLAGE		47. SIGNATURE OF CITY		48. SIGNATURE OF COUNTY	
49. SIGNATURE OF STATE		50. SIGNATURE OF DEPARTMENT		51. SIGNATURE OF RECORDS	
52. SIGNATURE OF HEALTH		53. SIGNATURE OF COUNTY		54. SIGNATURE OF TOWNSHIP	
55. SIGNATURE OF VILLAGE		56. SIGNATURE OF CITY		57. SIGNATURE OF COUNTY	
58. SIGNATURE OF STATE		59. SIGNATURE OF DEPARTMENT		60. SIGNATURE OF RECORDS	
61. SIGNATURE OF HEALTH		62. SIGNATURE OF COUNTY		63. SIGNATURE OF TOWNSHIP	
64. SIGNATURE OF VILLAGE		65. SIGNATURE OF CITY		66. SIGNATURE OF COUNTY	
67. SIGNATURE OF STATE		68. SIGNATURE OF DEPARTMENT		69. SIGNATURE OF RECORDS	
70. SIGNATURE OF HEALTH		71. SIGNATURE OF COUNTY		72. SIGNATURE OF TOWNSHIP	
73. SIGNATURE OF VILLAGE		74. SIGNATURE OF CITY		75. SIGNATURE OF COUNTY	
76. SIGNATURE OF STATE		77. SIGNATURE OF DEPARTMENT		78. SIGNATURE OF RECORDS	
79. SIGNATURE OF HEALTH		80. SIGNATURE OF COUNTY		81. SIGNATURE OF TOWNSHIP	
82. SIGNATURE OF VILLAGE		83. SIGNATURE OF CITY		84. SIGNATURE OF COUNTY	
85. SIGNATURE OF STATE		86. SIGNATURE OF DEPARTMENT		87. SIGNATURE OF RECORDS	
88. SIGNATURE OF HEALTH		89. SIGNATURE OF COUNTY		90. SIGNATURE OF TOWNSHIP	
91. SIGNATURE OF VILLAGE		92. SIGNATURE OF CITY		93. SIGNATURE OF COUNTY	
94. SIGNATURE OF STATE		95. SIGNATURE OF DEPARTMENT		96. SIGNATURE OF RECORDS	
97. SIGNATURE OF HEALTH		98. SIGNATURE OF COUNTY		99. SIGNATURE OF TOWNSHIP	
100. SIGNATURE OF VILLAGE		101. SIGNATURE OF CITY		102. SIGNATURE OF COUNTY	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

00661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, Maryland				c. LENGTH OF STAY IN 1b 23 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle L. Last Wolfe				4. DATE OF DEATH Month January Day 8, Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/25/1889	
9. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. 69		IF UNDER 24 HRS. Months 69 Days 69 Hours 69 Min. 69			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Wolfe, John L.				14. MOTHER'S MAIDEN NAME Smith, Julia			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Aortic Aneurysm rupture DUE TO (b) Arteriosclerosis DUE TO (c) 8 years				INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to January 8, 1959 , that I last saw the deceased alive on January 8, 1959 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. E. Mance				ADDRESS (Street, city or town, state) Oakland Md			
PHYSICIAN'S NAME (Type) A. E. Mance, M. D.				DATE SIGNED Jan 19 59			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/12/59		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich				ADDRESS Oakland Md.			
24a. REC'D BY REGISTRAR JAN 16 '59				24b. REGISTRAR'S SIGNATURE Arthur L. Krase			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES E. WILSON		45		M		W		1880		BALTIMORE		BALTIMORE		MD		USA	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT		STATE OF INTERMENT	
JAN 15 1925		BALTIMORE		BALTIMORE		MD		USA		JAN 15 1925		BALTIMORE		BALTIMORE		MD	
CAUSE OF DEATH		MANNER OF DEATH		DURATION OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISON		PREVIOUS DRUGS	
HEART DISEASE		NATURAL		2 WEEKS		NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. E. Wilson		J. E. Wilson		J. E. Wilson		J. E. Wilson		J. E. Wilson		J. E. Wilson		J. E. Wilson		J. E. Wilson		J. E. Wilson	

THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, HAS RECEIVED THE FOLLOWING REPORT OF DEATH, AND THE SAME IS HEREBY CERTIFIED TO BE TRUE AND CORRECT.

ATTEST:

JOHN E. WILSON, DEATH REGISTRAR

JAN 15 1925